

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030728

STATE FILE NUMBER

Registration District No. 193 Primary Registration District No. 3022 Registrar's No. 113

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 5 1962

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harrison</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany Mo</u> Length of stay in 1b <u>9 wks.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wald Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u> c. CITY OR TOWN <u>Ridgeway Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Ridgeway Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Wilson</u> Middle <u>Ellsworth</u> Last <u>Wilson</u> <b>4. DATE OF DEATH</b> Month <u>8</u> - Day <u>25</u> - Year <u>62</u>			<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-25-90</u> <b>9. AGE (last birthday)</b> <u>90</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life even if retired) <u>Farmer-Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u> <b>11. BIRTHPLACE</b> (City and state or country) <u>Meigs Co W.Va.</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>		
<b>13a. FATHER'S NAME</b> <u>Dr. Col. Ellsworth</u> <b>13b. MOTHER'S MAIDEN NAME</b> <u>Susie Vanderpool</u> <b>14. NAME OF HUSBAND OR WIFE</b> <u>Maud Ellsworth</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u> <b>17. INFORMANT</b> <u>Maud Ellsworth</u> Address <u>Ridgeway Mo</u>			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Arricular Fibrillation</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 mo</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ <b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____
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21. I attended the deceased from 6-19-62 to 8-25-62 and last saw him alive on 8-25-62  
 Death occurred at \_\_\_\_\_ A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Merian Clark M.D.</u> <b>22b. ADDRESS</b> <u>Bethany Mo.</u> <b>22c. DATE SIGNED</b> <u>8/28/62</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u> <b>23b. DATE</b> <u>8-27-62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Yashen Cemetery</u> <b>23d. LOCATION</b> (City, town, or county) (State) <u>49th St Yashen Mo.</u>
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<b>24. FUNERAL DIRECTOR</b> <u>Boyer Funeral Home</u> <b>ADDRESS</b> <u>Ridgeway</u> <b>25. DATE RECD. BY LOCAL REG.</b> <u>8-28-62</u> <b>26. REGISTRAR'S SIGNATURE</b> <u>Jella Mayey</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert R. Boggs

Licensed Embalmer No. 33-76

P. O. Address Ridgeway mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.